Mental Health Services Utilization in the Healthy Families Program

2011-12 Benefit Year

California Managed Risk Medical Insurance Board

Benefits and Quality Monitoring Division

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Healthy Families Program

MRMIB provides and promotes access to affordable coverage for comprehensive, high quality, and cost effective health care services to improve the health of Californians.

Janette Casillas
Executive Director
Managed Risk Medical Insurance Board

Ellen Badley
Deputy Director
Benefits & Quality Monitoring Division

Muhammad Nawaz
Research Manager II
Benefits & Quality Monitoring Division

Juanita Vaca
Research Analyst II
Benefits & Quality Monitoring Division

Table of Contents

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Executive Summary

Introduction

The Mental Health Services Utilization Report for the Healthy Families Program (HFP) presents information on mental health services provided to HFP subscribers from October 1, 2011 through September 30, 2012 (the 2011-12 benefit year). This includes services provided by HFP health plans and by county mental health departments for subscribers with a Seriously Emotionally Disturbed (SED) condition.

Each benefit year, HFP health plans are required to report to the Managed Risk Medical Insurance Board (MRMIB) on both the number of subscribers that received mental health services from the plan and the number of referrals made by plan, providers or plan contractors to county mental health departments for an SED assessment. In addition, the Department of Health Care Services (DHCS) provides information on the number of subscribers treated for an SED condition, the ages of the subscribers treated, the associated expenditures and the expenditures by service type.

MRMIB uses this information to monitor plan referrals and track trends in cost and services to ensure that HFP subscribers are receiving medically necessary covered mental health services.

Background

The HFP health plans provide coverage for the diagnosis and medically necessary treatment of mental health conditions, including Severe Mental Illnesses (SMI) such as schizophrenia, schizoaffective disorder, bipolar disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa. Health plans are required to refer subscribers to the county mental health department for an assessment if the plan believes the subscriber has an SED condition.

Once a subscriber is determined by the county to have an SED condition, county mental health departments provide mental health services and treatment for the SED condition, which is known as the "SED carve-out." The subscriber's HFP health plan continues to be responsible for providing health and mental health benefits for non-SED conditions.

Key Findings

Analysis of data submitted by health plans and DHCS revealed numerous key findings:

- In 2011-12, health plans provided mental health services to 3.6 percent of all enrolled subscribers compared to 2.8 percent in 2010-11.
- While state and national studies indicate that as many as one in four children under the age 19 need mental health services, the number of HFP subscribers receiving services is well below this estimate.
- Seven plans provided mental health services to more than 3 percent of their HFP subscribers. This is an improvement from 2010-11, when only four plans exceeded 3 percent.
- During the 2011-12 benefit year, a total of 3,208 subscribers were referred to county mental health departments for assessment of an SED condition, a significant increase over last year when only 2,170 subscribers received a referral.
- Nearly half or 47 percent of the referrals came from health plans, providers or plan contractors. The remainder came from other sources, including juvenile justice systems, schools or self-referrals.
- County mental health departments approved more than three-quarters or 79 percent of referrals. This is an increase from the prior year when 73.3 percent were approved.
- During 2011-12, a total of 8,415 subscribers ages 18 and younger or less than 1 percent received services for an SED condition.

- The majority of subscribers or 80 percent receiving mental health or treatment services for an SED condition were over the age of nine, which is consistent with the previous benefit year.
- Total expenditures for subscribers receiving treatment for an SED condition increased from $29 million in 2010-11 to $31 million in 2011-12.
- Mental health services, which include assessment, evaluation, therapy and rehabilitation, accounted for over three-quarters or 78.4 percent of total expenditures.
- The average cost per case was $3,736; this is higher than 2010-11 when the average cost was $3,427.

Conclusion

Overall, both HFP plans and the county mental health departments showed continued improvement in addressing the mental health needs of HFP subscribers. For example, the 2011 HEDIS report for HFP revealed that health plans reported 4.3 percent of subscribers aged 13-17 received mental health services compared to 3.9 percent in 2010. However, when compared to research estimates of need, there clearly continues to be a wide gap, and many children who likely need and should receive care are going without. Without further research, it is unclear if this gap is attributable to limited access to services, cultural, language and/or societal stigmas against mental health treatment or a combination.

During 2013, HFP subscribers are transitioning to the Medi-Cal Program and as a result, this is the last Mental Health Services Utilization report for HFP that MRMIB will publish. For that reason, this report includes lessons learned and recommendations gleaned from the staff experience with the implementation of strategies to improve access and utilization of mental health services. In HFP, the carve-out for SED conditions often led to confusion on the part of subscriber families attempting to navigate two systems for accessing care and challenges between plans, county mental health departments and providers for coordination.

To address these problems, MRMIB established a Mental Health Workgroup comprised of representatives from health plans, county mental health departments, relevant associations and the Department of Health Care Services. MRMIB staff found that regular meetings among this workgroup provided a forum for discussion of issues related to coordination and referral of SED services, served to identify systemic problems attributed to processes between the counties and the plans, and provided a platform for the development of mutually agreeable solutions among the parties. Where the responsibility for delivery of services is shared between HFP plans and other state departments, MRMIB found that convening the Mental Health Workgroup to be an essential tool in the identification of systemic problems and development of workable strategies to address them.

Academic research shows that appropriate screening and early intervention with treatment and support helps prevent mental health problems from worsening. Early detection of mental disorders results in substantially shorter and less disabling courses of impairment for children and adolescents. As utilization data shows that there is an unmet need for adolescents, further study is essential to determine how to more effectively reach this population.

Health Plan Provided Mental Health Services

Health plans provide coverage for the diagnosis and medically necessary treatment of mental health conditions, including SMI. SMI includes schizophrenia, schizoaffective disorder, bipolar disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa. There are no limits on the number of outpatient or inpatient services provided to treat SMI. Members pay a $5 or $10 co-payment for outpatient services and there is no charge for inpatient services.

In addition to coverage for SMI, mental health services in HFP cover both inpatient and outpatient treatment for subscribers who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce and bereavement.

In 2008, MRMIB contracted with APS Healthcare, Inc. (APS) and San Jose State University to review the mental health and substance abuse services provided by HFP plans. The study found that the most typical mental health diagnosis among HFP subscribers was attention deficit hyperactivity disorder (ADHD) followed by depressive disorders and anxiety disorders.[1]

The health plans provide mental health services in a variety of ways, including through:

- Mental health providers in the plan's network;
- External organizations, such as managed behavioral health organizations;
- Local mental health agencies; or
- In the case of Kaiser Foundation Health Plan, all mental health services are provided within Kaiser's system.

[1] APS Healthcare, Inc. and San Jose State University (September 2010). *Mental Health and Substance Abuse Services Provided by Health Plans Participating in the Healthy Families Program.*

County Mental Health Department Provided Services (The SED "Carve-Out")

County mental health departments provide mental health services and treatment for HFP subscribers with an SED condition. Statutes and Regulations[2] governing HFP require that HFP plans refer a subscriber to the county mental health department if the plan suspects the subscriber has an SED condition. Generally speaking, subscribers with SMI also qualify for an SED referral for services with the exception of autism.

A SED condition is described as one or more of the following:

- The child has substantial impairment in self-care, school functioning, family relationships or the ability to function in the community and is at risk of removal from the home or has been removed and/or the impairments have been present for more than six months and are likely to continue for more than a year.
- The child displays psychotic features and there is a risk of suicide or violence.

Once the plan refers a subscriber to the county, the county conducts an assessment to determine if the subscriber has an SED condition. County assessments for SED are to be completed within five working days from the date of referral for subscribers already receiving inpatient services from their HFP health plan, and no later than 30 calendar days from the date of referral in all other cases, provided that referral information is complete.

If the subscriber is determined by the county to have an SED condition, the county will provide services and care associated with the subscriber's SED condition. The subscriber's HFP health plan continues to be responsible for providing health and mental health benefits for non-SED conditions.

[2] California Insurance Code Section 12693 et.seq. and Title 10 of the California Code of Regulations.

Coordination Between County Mental Health Departments and HFP Health Plans

Memorandum of Understanding (MOU) Requirement

HFP health plans are required to develop an MOU for referral of subscribers to the county mental health department in each county in which the plan serves HFP. The purpose of the MOU is to facilitate coordination of services for subscribers referred for an SED assessment.

The MOU includes the following elements:

- Referral protocol
- Consultation and care coordination
- Medical records and exchange of information
- Provider education
- Health plan benefits for SED subscribers
- Dispute resolution process, and
- Plan and county liaison functions and monitoring.

MRMIB has found that numerous county mental health departments' staff is unaware of the MOU or its provisions, often due to staff turnover and lack of training. As a result, the MOU may not fully assure the delivery of necessary SED services.

Resolution of Access Issues

MRMIB holds quarterly workgroup meetings to facilitate communication between MRMIB, DHCS, county mental health departments and HFP plans. The meetings also provide an opportunity to address and resolve issues related to SED referrals and the provision of mental health services.

In addition, MRMIB staff work to resolve problems reported by counties, plans and parents of subscribers enrolled in HFP, including coordinating payment for prescription drugs, clarifying county and/or plan roles and responsibilities, educating parents regarding mental health benefits and following up on SED determinations.

Prescription Drug and Laboratory Services

HFP health plans provide inpatient and outpatient mental health services, including prescription drugs, and provide benefits consistent with the mental health parity provisions of the Knox-Keene Act.[3] Services to treat HFP children with SED provided through the counties are reimbursed through the Short-Doyle Medi-Cal (SD/MC) claiming system. The MOUs between HFP health plans and counties require county mental health departments to provide medically necessary outpatient medications, while the HFP plans provide inpatient and outpatient mental health services, including laboratory services that are part of the HFP child's outpatient treatment plan. However, any medically necessary covered mental health services, including prescription drugs, must be provided by the HFP plan if the covered services are not provided by the county mental health department.

Although, the SD/MC claiming system was never modified to allow counties to submit claims and obtain reimbursement for prescription drugs, in some cases, counties had an infrastructure to provide these drugs without reimbursement. It is the HFP health plans that ultimately provided the prescription medications. Further, Kaiser does not refer children to the counties for SED evaluation but instead provides these services within Kaiser's integrated model. For this reason, the data in chart 7 under-represents the actual costs associated with providing medically necessary services to treat HFP children with SED.

MRMIB reports the data on the SED Carve-Out services primarily to ensure that HFP children receive medically necessary services to treat SED conditions, understand the associated costs and assess the effectiveness of the SED Carve-Out. Throughout the

[3] The Knox Keene Service Plan Act of 1975, as amended. Health and Safety Code §1374.72

years of HFP, there have been and continue to be challenges with coordination, data reporting, claims submission and reimbursement, as well as stigma associated with seeking mental health services. Clearly this is an area for ongoing improvement in developing a delivery system that is consumer-oriented.

Kaiser Foundation Health Plan (Kaiser) Delivery System

Data in this report shows that Kaiser provided one of the highest rates of mental health services, but did not refer any subscribers to the county for an SED assessment or treatment. Kaiser has an integrated delivery system and provides subscribers with treatment for SED conditions. Each medical center has a psychiatry department with psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists, medical social workers, psychiatric clinical nurse specialists, psychiatric nurse practitioners and psychiatric nurses. Kaiser generally does not refer children who may have an SED condition to the county mental health departments. Instead Kaiser uses specialized in-house health teams to serve children and adolescents.

Need for Mental Health Services

Understanding how many children need mental health services, particularly those that may need treatment for an SED condition, can be challenging. However, several reports and briefs provide insight into the number of children needing services:

- A report on the prevalence of SMI rates in children under age 18 in California, estimates 8.9 percent need treatment for SMI. [4]

- A report on the prevalence of SED and Substance Use Disorder (SUD) rates in children ages 0-17 in California, estimates 7.56 percent need treatment for SED and 8.15 percent need treatment for SUD.[5]

- According to the 2009 California Health Interview Survey (CHIS), approximately 13 percent of teens indicated they needed help for emotional/mental health problems.[6]

- An Urban Institute review of literature and data sources on mental health for children estimates that over a quarter of children in the United States will have a serious mental health problem at some time during their childhood. [7]

- A brief by the National Center for Children in Poverty indicates that one in five children has a diagnosable mental disorder and one in 10 has a serious mental health problem that impairs how they function at home and in school. [8]

- According to a recent national study on drug use and health, two million youth aged 12 to 17, or approximately 8 percent of this population, experienced a major depressive episode in the past year. The study also found that these young people had twice the rate of illicit drug use (36 percent) compared to those who did not have a depressive episode.[9]

Autism

Autism Spectrum Disorders (ASD) are a group of neurodevelopmental disorders usually diagnosed in young children. These children have difficulty communicating and exhibit repetitive behavior. In addition to developmental impairment, children with ASDs are also often diagnosed with other health

[4] Charles Holzer, Ph.D., University of Texas, Medical Branch, as reported on the California Department of Mental Health website: http://www.dmh.ca.gov/Statistics_and_Data_Analysis/docs/Population_by_County/California.pdf

[5] California Mental Health; Substance Abuse System Needs Assessment Final Report February 2012, Technical Assistance Collaborative Human Services Research Institute.
[6] Source: 2009 California Health Interview Survey.
[7] McMorrow, Stacey & Howell, Embry (July 2010). *State Mental Health Systems for Children: A Review of the Literature and Available Data Sources*. Urban Institute.
[8] Stagman, Shannon & Cooper, Janice L. (April 2010). *Children's Mental Health: What Every Policymaker Should Know*. National Center for Children in Poverty.
[9] Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-45, HHS Publication No. (SMA) 12-4725. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

problems such as respiratory, gastrointestinal and neurologic conditions. It is estimated that about 1 percent of children aged 3 to 17 have a current diagnosis of ASD[10] . Autism and pervasive developmental disorder (PDD) are among the conditions defined as SMIs, and as such, health plans must provide subscribers with all medically necessary covered services to treat these conditions without limits on visits or hospital days.

Early detection of autism/PDD and early intervention have been shown through various studies to improve symptoms[11]. Typically, a combination of behavioral and other therapies including education are used to treat and improve symptoms of autism/PDD in young children. However, over the last decade, health plans have disputed the provision of certain behavioral treatments for autism/PDD called Applied Behavioral Analysis (ABA) or Behavioral Health Treatment (BHT). The plans' objections included questioning whether these services were medical rather than educational services and whether health plans are required to provide services that are rendered by an unlicensed provider.

Recent legislation[12] articulated additional ABA related requirements for health plans but exempted plans within HFP and CalPERS from these new requirements. In 2012, the Department of Managed Health Care (DMHC) adopted regulations clarifying that this law did not limit HFP and CalPERS plans' existing obligations to provide ABA under existing mental health parity law, under which DMHC previously considered plans obligated to provide ABA services when medically necessary and rendered by a licensed provider.

Based upon recent studies, it could be extrapolated that as many as 9,000 subscribers in HFP may have had an ASD during the 2011-12 benefit year. In preparing the Mental Health Report, MRMIB queried its encounter data base to assess the number of subscribers receiving services with a diagnosis of ASD. While this data base remains incomplete, in 2012, HFP health plans reported approximately 1,500 subscribers with an encounter that included an ASD diagnosis. Unfortunately, as a result of the HFP transition to Medi-Cal, the encounter database and analysis will remain incomplete, and the actual number of subscribers in HFP with an ASD cannot be accurately determined.

When the California Mental Health Parity law[13] was enacted establishing requirements for the medically necessary treatment of SMIs, the Medi-Cal Program was specifically exempted from its provisions. As a result, health plans contracting with Medi-Cal are not subject to the same requirements as plans providing coverage under HFP. With the 2013 transition of HFP children to Medi-Cal, families with ASD children will therefore be required to navigate a different system that delivers services through multiple entities, including regional centers, mental health plans and fee-for-service specialty mental health providers.

Other Utilization Monitoring Activities

MRMIB utilizes a number of monitoring strategies to ensure that HFP subscribers receive needed health care services. In addition to providing information on the number of subscribers receiving mental health services and referrals for assessment of an SED condition, the HFP health plans are also required to report on a selection of Healthcare Effectiveness Data and Information Set (HEDIS) measures, including *Mental Health Utilization* and *Identification and Treatment of Alcohol and Other Drug Services*.

The Mental Health Utilization measure evaluates the percentage of subscribers aged 13 to 17 who received inpatient mental health treatment, intensive outpatient mental health treatment, or outpatient mental health treatment, including emergency department visits. The health plans reported that 4.3 percent of continuously enrolled subscribers received mental health services in 2011, an improvement from 2010 when the rate was 3.9 percent.

The need for mental health services/intervention and substance abuse often go together and early identification and treatment are

[10] Mental Health Surveillance Among Children – United States, 2005-2011, Centers for Disease Control and Prevalence, Morbidity and Mortality Weekly Report, May 17, 2013.
[11] NIM- A Parent's Guide to Autism Spectrum Disorder, 2011
[12] SB 946, Chapter 650, Statutes 2011
[13] AB 88, Chapter 534, Statutes 1999

necessary for good overall health. According to estimates from the National Survey on Drug Use and Health, 12 percent of adolescents in California ages 12 to 17 reported use of an illicit drug in the month prior to the 2010-11 survey, while 5 percent of these adolescents said they needed but did not receive treatment for illicit drug use. Past month alcohol use in this age group for California is 14 percent, and 8 percent of adolescents aged 12 to 17 report binge drinking in the month prior to the survey. Nearly 5 percent of 12 to 17 year-olds report needing, but not receiving, treatment for alcohol use. However, in 2011, less than one (0.9) percent of HFP subscribers ages 13 to 17 received alcohol or other drug treatment services, an improvement from 2010 when the rate was 0.4 percent.

Both the HEDIS measures and the information provided by the health plans measure the number of HFP subscribers receiving mental health services from the plan. However, there are several significant differences. HEDIS data is collected for each calendar year and only subscribers who are continuously enrolled in the plan for the majority of the year are included in this measure. The most recent HEDIS results available are for the 2011 calendar year and only represent services provided to subscribers ages 13 to 17.

The information presented in Table 1, includes plan provided mental health services for the period of October 1, 2011 through September 30, 2012 and includes all subscribers under the age of 19, regardless of the amount of time they were enrolled in the plan. Regardless of the source of data, it is concerning that the number of HFP subscribers receiving mental health services is significantly below what research data indicates is the need.

The most recent HEDIS report can be found at:
http://www.mrmib.ca.gov/MRMIB/HFP/2011_HFP_HE_DIS.pdf

Teen Survey

MRMIB developed procedures and a questionnaire for the Teen Health Care Experience Survey[14]. The survey addressed access to health care, confidentiality of health care, experience with health care, and the health, safety and wellness of teens during 2011. A total of 6,926 eligible HFP teens completed the survey. Included in the survey were questions on:

- Family abuse of alcohol or drugs
- Bullying
- Suicide
- Sexual orientation
- Sexual abuse
- Abuse of over-the-counter drugs
- Physical abuse
- Use of steroids without a prescription
- Self-abuse
- Use of prescription drugs such as Valium, OxyContin or Vicodin without a prescription

In the survey, 10 percent of teens reported a problem receiving mental health therapy or counseling. Six percent of teens felt they needed treatment or counseling for mental health, substance abuse or emotional problems. Doctors were the most likely to talk to teens about emotions or moods (19 percent) and less likely to talk to teens about much serious mental health issues, such as alcohol and substance use, suicide, bullying and physical or self-abuse. Suicide is the second leading cause of death for adolescents aged 12-17 years in 2010.[15]

[14] Healthy Families Program 2012 Teen Health Care Experience Survey, http://www.mrmib.ca.gov/MRMIB/HFP/HFP_2012_Teen_Health_Care_Experience_Survey_Report.pdf
[15] Mental Health Surveillance Among Children – United States, 2005-2011, Centers for Disease Control and Prevalence, Morbidity and Mortality Weekly Report, May 17, 2013.

Lessons Learned and Recommendations

With the transition of HFP subscribers to the Medi-Cal Program underway, this is the final report MRMIB will publish on Mental Health Services Utilization. However, strategies used by MRMIB to increase access and utilization and to assess the provision of mental health services to lower income subscribers may be useful to policymakers and other state Children's Health Insurance Programs.

Low utilization rates for mental health and substance abuse services in HFP have been a long standing concern to MRMIB. To improve the coordination and delivery of mental health services, MRMIB facilitates quarterly mental health workgroup meetings with HFP plans, county mental health departments and the state Department of Mental Health. MRMIB found this workgroup essential for the identification of best practices in the coordination and provision of care to subscribers with serious emotional disturbances (SED), as well as in addressing issues concerning basic mental health and substance abuse services provided by HFP health plans. In addition to the activities of the mental health workgroup, MRMIB strategies for addressing low utilization rates were also informed by experts in mental health and substance abuse who participated in the HFP Advisory Panel and a separate Advisory Committee on Quality for the HFP Program. MRMIB recommends that policymakers and other state programs implement similar advisory groups of subject matter experts and subscriber families to assist in the development of quality improvement initiatives and outreach efforts.

This report demonstrates significant growth in access and service delivery to HFP subscribers with mental health disorders and SED covered under HFP from previous years. However, many more subscribers who may need services are not being identified or adequately screened and therefore are not referred. As a result, these subscribers do not receive needed services under the current system of care delivery. Results from the Teen Survey show key areas, such as suicide or abuse of alcohol and drugs, that would trigger a mental health referral by a provider are discussed very infrequently. As a result, we recommend that providers engage in more systemic inquiry, perhaps through the use of a standardized screening instrument.

The challenge of navigating multiple systems may be daunting to many families and is likely to be one of the drivers of underutilization of mental health services. Carving out services in a segregated approach is not client-centered, efficient or accountable. MRMIB found it challenging to monitor and report on the effectiveness of the system given that responsibility for service delivery was bifurcated in HFP. Where care is delivered in a bifurcated manner, all entities must work collaboratively to inform and educate families on the array of benefits and services available. Health plans and counties must be accountable to ensuring that subscribers receive necessary care and treatment by assisting families who have trouble navigating the system. Finally, as the program administrator, the state is responsible to see that the system delivers the services when needed. In contrast, a coordinated delivery system, such as Kaiser's demonstrates that a simplified, integrated system is more consumer friendly and should be the ultimate goal.

Conclusion

Although HFP plans have demonstrated improvement in the delivery of mental health services to HFP subscribers, it is concerning that as many as one quarter of HFP subscribers may need mental health services. Even when the number of subscribers' ages 13 to 17 years of age receiving SED services is added to the 2011 HEDIS data for subscribers of the same age, the number of HFP subscribers receiving mental health services is still well below this estimate.

Mental health is a fundamental component of a child's overall health, social and emotional development and success in school and life. This report and recent studies on the need for mental health services indicate that there is a need for widespread use of screening tools to identify children that need mental health services and ensure they receive the appropriate care. Early identification and intervention will minimize the negative impacts on children so that they can be successful in all areas of life and is likely to avoid higher costs of treatment later in life.

Table 1. Plan Provided Mental Health Services as a Percentage of Total Enrollments, 2007-08 through 2011-12

Health Plan	2007-08	2008-09	2009-10	2010-11	2011-12
Health Plan of San Joaquin	0.0%	1.0%	1.0%	1.1%	5.5%
San Francisco Health Plan	0.0%	4.3%	5.5%	2.4%	5.4%
Kaiser Foundation Health Plan*	6.0%	6.4%	3.6%	3.4%	5.1%
Anthem Blue Cross EPO and HMO	2.4%	0.3%	0.2%	3.5%	4.8%
Community Health Group	2.8%	2.9%	2.8%	3.5%	3.7%
Inland Empire Health Plan	3.1%	3.9%	2.5%	3.5%	3.7%
Santa Clara Family Health Plan	1.2%	1.6%	3.3%	2.3%	3.1%
Community Health Plan	0.5%	0.6%	2.3%	0.4%	2.5%
Contra Costa Health Plan	1.0%	1.8%	2.3%	2.2%	2.4%
CalOptima	1.6%	1.4%	1.6%	2.0%	2.4%
Ventura County Health Care Plan	2.2%	1.6%	0.2%	2.2%	2.3%
Health Net EPO and HMO	1.9%	N/P	2.0%	2.5%	2.1%
Kern Family Health System	0.9%	2.1%	1.6%	2.2%	2.0%
Health Plan of San Mateo	0.0%	1.0%	2.3%	2.2%	2.0%
CenCal Health	1.0%	0.4%	0.1%	2.6%	1.9%
Central California Alliance for Health	2.1%	1.4%	0.8%	0.5%	1.7%
Alameda Alliance for Health	1.0%	0.9%	0.0%	1.8%	1.6%
Partnership Health Plan	N/P	N/P	N/P	2.7%	1.1%
Molina Healthcare	3.1%	2.2%	2.0%	1.7%	1.1%
LA Care	0.0%	0.5%	1.0%	0.1%	1.0%
Blue Shield EPO and HMO	2.5%	2.3%	2.9%	2.9%	0.9%
Care 1st Health Plan	N/P	0.2%	0.2%	0.2%	0.6%
Total	**2.7%**	**1.9%**	**1.9%**	**2.8%**	**3.6%**

N/P = Not Provided

Note: Partnership Health Plan was not a HFP participating plan, so no data was reported until 2010-11.

***Subscribers enrolled in Kaiser Foundation Health Plan receive treatment for an SED condition within the Kaiser system and are not referred to the county. The number and percentage indicated in Table 1 represents all mental health services, including services to treat an SED condition.**

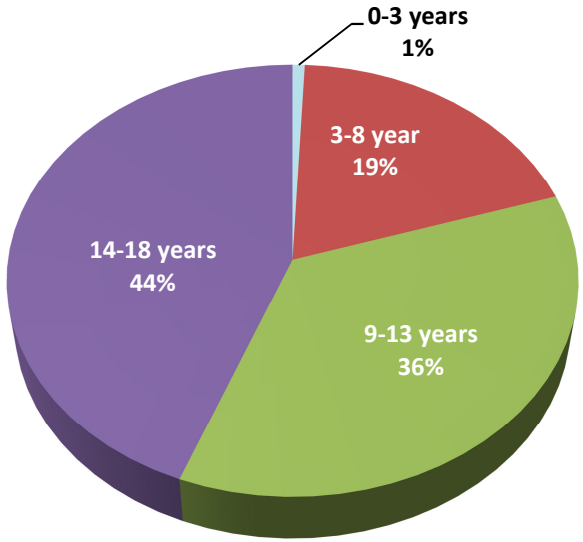
Key Findings:

- Of the 859,903 subscribers under age 19 enrolled in HFP during the 2011-12 benefit year, the health plans provided mental health services to 3.6 percent of HFP subscribers. This includes services for non-SED conditions and for the treatment of an SED condition while a subscriber is waiting for a determination from the county.
- Four health plans provided mental health services to more than 4 percent of HFP enrollees during the 2011-2012 benefit year. They are:
  - Health Plan of San Joaquin
  - San Francisco Health Plan
  - Kaiser Foundation Health Plan
  - Anthem Blue Cross (EPO & HMO)

  By comparison, no plans exceeded 4 percent in 2010-11.
- Analysis of trends in plan provided mental health services shows significant variation from year to year in some plans, which could be an indication of the challenges that some plans have in reporting use of mental health services.
- Kaiser has historically provided mental health services at nearly twice the rate of all other plans, likely due to the fact that Kaiser does not refer subscribers with an SED condition to the county for services.

Chart 1. Mental Health Services Provided by Health Plans as a Percentage of Total Enrollment

Chart 2. Mental Health Services By Age Group



Key Findings:

- Health plans provided mental health services to nearly 4 percent of subscribers enrolled during the 2011-12 benefit year, an increase of almost 1 percent from 2010-11.
- A total of 80 percent of mental health services were provided to subscribers over the age of nine.

Table 2. SED Referrals from All Sources

Plan Name	Total SED Plan Referrals	*Total SED Other Referrals	All Sources	Total Number Approved	Total Percent Approved
San Francisco Health Plan	212	0	212	212	100.0%
Santa Clara Family Health Plan	148	0	148	148	100.0%
Contra Costa Health Plan	128	0	128	128	100.0%
Blue Shield EPO and HMO	55	0	55	55	100.0%
Alameda Alliance for Health	3	0	3	3	100.0%
Care1st Health Plan	18	67	85	79	92.9%
Kern Family Health Care	216	0	216	190	88.0%
Anthem Blue Cross EPO and HMO	107	799	906	745	82.2%
CalOptima	4	55	59	47	79.7%
CenCal Health	4	0	4	3	75.0%
Inland Empire Health Plan	43	72	115	82	71.3%
L.A. Care	0	27	27	12	44.4%
Health Plan of San Joaquin	233	333	566	397	70.1%
Health Net EPO and HMO	226	347	573	366	63.9%
Molina Healthcare	18	1	19	12	63.2%
Community Health Plan	26	9	35	19	54.3%
Community Health Group	43	0	43	26	60.5%
Central California Alliance for Health	5	2	7	1	14.3%
Ventura County Health Care Plan	7	0	7	0	0.0%
Health Plan of San Mateo	0	0	0	0	0.0%
Partnership Health Plan	0	0	0	0	0.0%
Total	**1,496**	**1,712**	**3,208**	**2,525**	**78.7%**

*Health plans provide self reported data on the referrals. The reliability of this data is based on how effective the plans monitor the referrals.

Key Findings:

- Of the 859,903 HFP enrolled subscribers, a total of 3,208 were referred to the counties for an SED assessment.
- A total of 47 percent of referrals came from the health plans, their contractors or providers and the remainder came from other sources, such as juvenile justice systems, schools or self-referrals.
- Of the 3,208 subscribers referred to the counties for an SED assessment, nearly three-quarters or 79 percent were approved.
- Five health plans had an approval rate of 100 percent:
  - San Francisco Health Plan
  - Santa Clara Family Health Plan
  - Contra Costa Health Plan
  - Blue Shield
  - Alameda Alliance for Health

Appendix A contains information on referrals as a percentage of total HFP enrollments.

Chart 3. Total Number of Referrals, 2004-05 through 2011-12

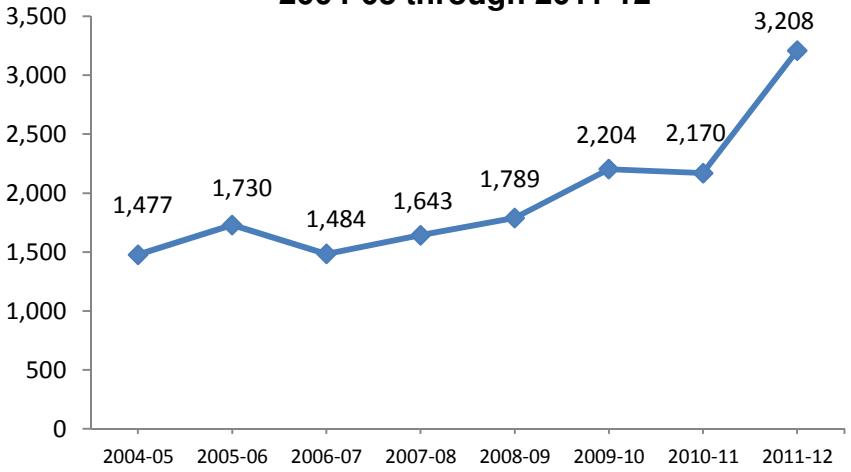
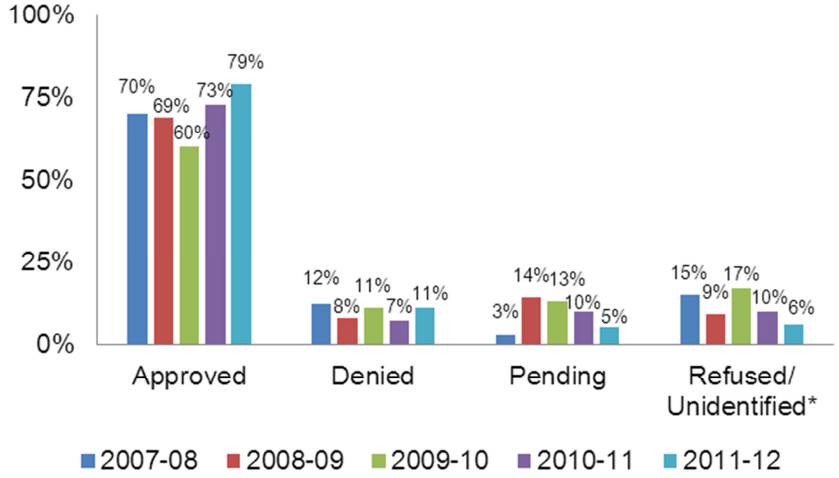


Chart 4. Referral Status 2007-08 through 2011-2012



*Family decision not to have child assessed by County Mental Health Department (CMHD) following plan referral or refused plan referral to the CMHD.

Key Findings:

- The total number of subscribers referred to the county for an SED assessment has increased over the last seven years. However, referrals still account for less than 1 percent of enrolled subscribers.
- The percentage of referrals approved by the counties increased in 2011-12, with almost 80 percent receiving approval. This is an increase from the prior benefit year when only 73 percent were approved.

Chart 5. SED Caseload
2007-08 through 2011-2012

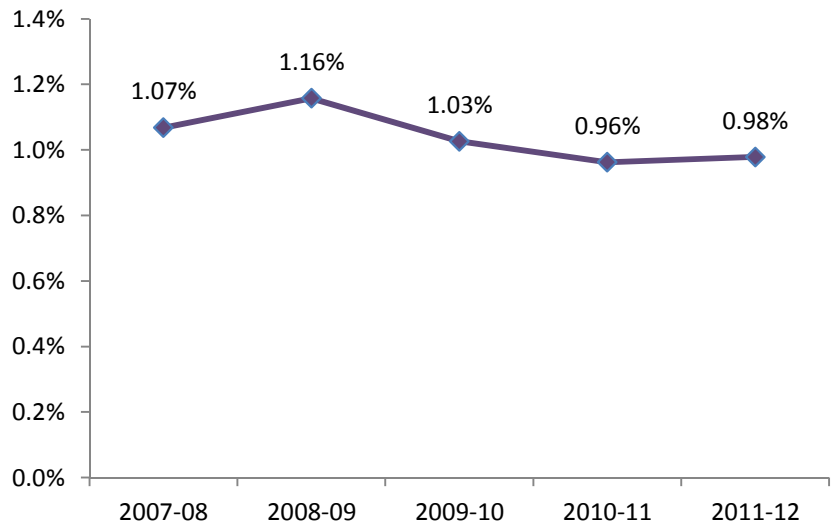
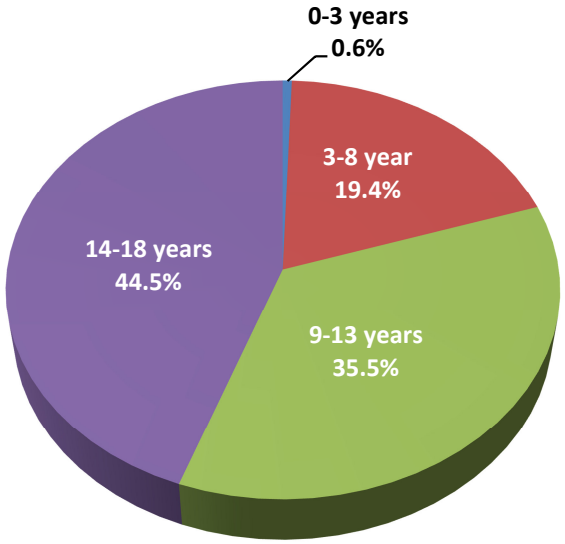


Chart 6. SED Caseload By Age Group



Key Findings:

- During the 2011-12 benefit year, about 1 percent of total HFP enrolled subscribers received services for an SED condition.
- The number of subscribers receiving services from the counties for an SED condition steadily increased from 2004 to 2009, peaking in the 2008-09 benefit year with over 10,000 subscribers receiving services. This was also the year when HFP enrollment peaked with over 920,000 subscribers enrolled in the program.
- The vast majority or 80 percent of subscribers receiving services for an SED condition are over the age of nine.

Chart 7. Total Expenditures 2007-08 through 2011-12

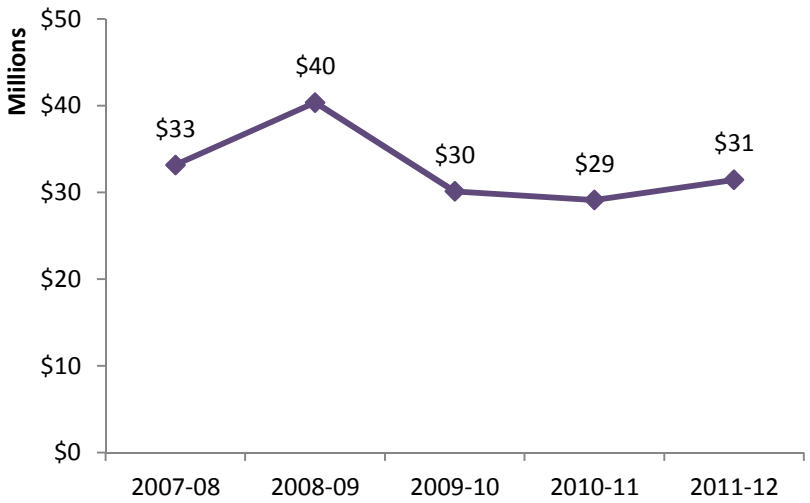
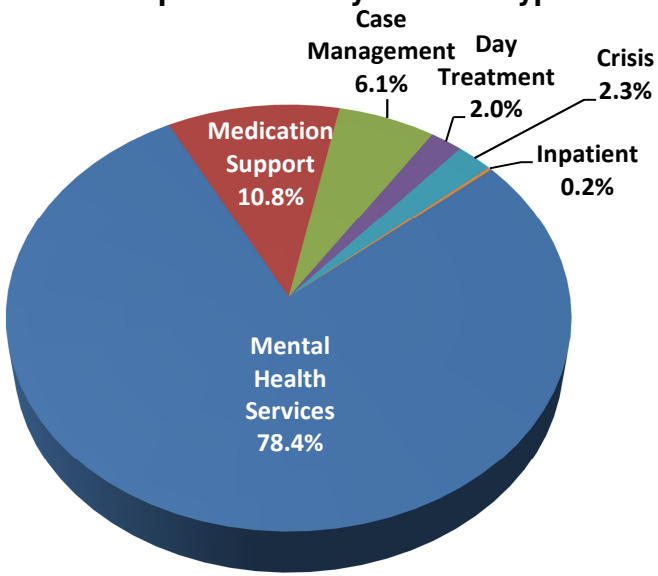


Chart 8. Expenditures by Service Type



Key Findings

- Total annual expenditures for HFP subscribers treated for an SED condition has declined over the last few years with slight increase in expenditures for 2011-12.
- Total expenditures in 2011-12 was $31 million, with the majority, 78.4 percent spent on mental health services. Mental Health Services includes assessment, evaluation, therapy and rehabilitation services.
- Medication Support, the second largest category accounted for approximately 11 percent. This category does not include the cost of prescription drugs, but includes prescribing activities, administration, dispensing and monitoring of psychiatric medication to alleviate the symptoms of mental illness.
- Case Management, the third largest category accounted for slightly more than 6 percent of cost. Case Management includes activities provided by county program staff to access medical, educational, social, prevocational, vocational, rehabilitative or other needed community services.
- Three service categories, Intensive Day Treatment, Crisis Intervention Services and Inpatient Services, account for less than 5 percent.
- Inpatient services, including adult residential treatment services and psychiatric inpatient services, accounts for less than 1 percent of total expenditures. However, only HFP subscribers who are 18 years of age qualify for these services.

Appendix A. Plan Referrals for SED Assessment by Source

HFP Participating Plan	Total HFP Members	Plan Referrals		Other Source		Total Referrals		Referrals Approved	
		Number	Percent of Plan Enrollment	Number	Percent of Plan Enrollment	Number	Percent of Plan Enrollment	Number	Percent of Referrals Approved by Counties
Alameda Alliance for Health	10,163	3	0.03%	0	0.00%	3	0.03%	3	100.0%
Anthem Blue Cross EPO and HMO	195,094	107	0.05%	799	0.41%	906	0.46%	745	82.2%
Blue Shield EPO and HMO	28,601	55	0.19%	0	0.00%	55	0.19%	55	100.0%
CalOptima	35,956	4	0.01%	55	0.15%	59	0.16%	47	79.7%
Care1st Health Plan	12,453	18	0.14%	67	0.54%	85	0.68%	79	92.9%
CenCal Health	9,379	4	0.04%	0	0.00%	4	0.04%	3	75.0%
Central California Alliance for Health	23,771	5	0.02%	2	0.01%	7	0.03%	1	14.3%
Community Health Group	24,159	43	0.18%	0	0.00%	43	0.18%	26	60.5%
Community Health Plan	9,918	26	0.26%	9	0.09%	35	0.35%	19	54.3%
Contra Costa Health Plan	4,663	128	2.75%	0	0.00%	128	2.75%	128	100.0%
Health Net EPO and HMO	136,257	226	0.17%	347	0.25%	573	0.42%	366	63.9%
Health Plan of San Joaquin	23,661	233	0.98%	333	1.41%	566	2.39%	397	70.1%
Health Plan of San Mateo	6,020	0	0.00%	0	0.00%	0	0.00%	0	0.0%
Inland Empire Health Plan	56,502	43	0.08%	72	0.13%	115	0.20%	82	71.3%
Kaiser Foundation Health Plan	191,831	0	0.00%	0	0.00%	0	0.00%	0	0.0%
Kern Family Health System	10,627	216	2.03%	0	0.00%	216	2.03%	190	88.0%
L.A. Care	11,504	0	0.00%	27	0.23%	27	0.23%	12	44.4%
Molina Healthcare	31,852	18	0.06%	1	0.00%	19	0.06%	12	63.2%
Partnership Health Plan	2,436	0	0.00%	0	0.00%	0	0.00%	0	0.0%
San Francisco Health Plan	7,165	212	2.96%	0	0.00%	212	2.96%	212	100.0%
Santa Clara Family Health Plan	16,889	148	0.88%	0	0.00%	148	0.88%	148	100.0%
Ventura County Health Care Plan	11,002	7	0.06%	0	0.00%	7	0.06%	0	0.0%
Total	**859,903**	**1,496**	**0.2%**	**1,712**	**0.2%**	**3,208**	**0.4%**	**2,525**	**78.7%**

Note: Plan Referrals include referrals submitted by HFP health plans, providers and plan contractors. Other Source Referrals include referrals from schools, juvenile justice, self referrals, etc.